York and Scarborough Teaching Hospitals
NHS Foundation Trust

Minutes

Public Council of Governors Meeting
10 June 2026

Chair: Martin Barkley

Public Governors: Linda Wild, East Coast of Yorkshire; Jean Flanagan, East Coast of Yorkshire; Peter Morley, Selby; Ros Shaw, City of York; Graham Lake, Ryedale & EY; Sandra Fox, Ryedale & EY; Paul Gibson, East Coast of Yorkshire

Appointed Governors: Cllr Jason Rose, CYC; Gerry Richardson, University of York; James Cannon, YOPA; Cllr Liz Colling, NYC; Cllr Tim Norman, ERYC

Staff Governors: Elena Clerici, York; Gary Kitching, York; Julie Southwell, York; Carol Popplestone, Scarborough/Bridlington;

Attendance: Andrew Bertram, Finance Director; Claire Hansen, Chief Operating Officer; Joseph Hague, Chief Nurse; Lydia Larcum, Interim Director of Workforce & Organisational Development; Lucy Brown, Director of Communications; Julie Charge, NED; Lorraine Boyd, NED; Rukmal Abeysekera, NED; Helen Grantham, NED; Jane Hazelgrave, NED; Matthew Taylor, NED; Mike Taylor, Assoc. Director of Corporate Governance; Tracy Astley, Governor & Membership Manager

Public: 4 members of the public

Apologies: Adnan Faraj, Scarborough/Bridlington; Mary Clark, City of York; James Hayward, East Coast of Yorkshire; Wendy Loveday, Selby; Rebecca Bradley, Community; Elizabeth McPherson, Carers Plus; Clare Smith, CEO; Chris Norman, MD YTHFM; Richard Reece, NED

26/16 Chair's Introduction and Welcome

Mr Barkley welcomed everybody and declared the meeting quorate. He introduced Joe Hague (chief nurse), Matthew Taylor (non-executive director), and Jim Cannon (voluntary sector stakeholder governor), with all three providing brief introductions.

26/17 Declarations of Interest (DOI)

The Council acknowledged the changes to the Declarations of Interest.

26/18 Minutes of the meeting held on the 11 March 2026

The minutes of the meeting held on the 11 March 2026 were agreed as a correct record.

26/19 Matters arising from the Minutes

Action Log

- 26/10 Cancer update – on agenda later in the meeting.

26/20 Chief Executive's Report

On behalf of Miss Smith, Mr Bertram gave an overview of the report which had previously been circulated with the agenda and highlighted the following.

- **My First 100 Days in the Organisation:** Miss Smith reported that, during her first 100 days, she had met with colleagues, MPs, local councillors and patient advocacy groups to better understand the views of the communities served by the Trust. This engagement is helping to inform the development of the Trust's clinical strategy and shape key priorities, including reducing corridor care, strengthening culture and leadership, improving the timeliness of care through community service development, and achieving financial sustainability through a clear clinical strategy and continuous quality improvement. She emphasised that this is not intended to be a final or top-down plan, but the beginning of an ongoing conversation about the future direction of the Trust, in which Governors will continue to play an important role.

- **Financial Plan:** Mr Bertram reported that the Trust's financial plan has not yet been approved by NHS England, as the current position does not achieve a balanced outcome. Although the Trust has a £62 million savings requirement, it is still forecasting an operating deficit of £22 million. A medium-term financial plan has been developed to return the Trust to financial sustainability over three years, but NHS England has indicated that this timeframe is too long and expects faster progress.

  He further advised that he, the Chair and the Chief Executive met with the national NHS England team the previous week to discuss the plan and respond to questions. Further queries were received, with responses requested by early July. Discussions with the regional NHS England team are continuing.

- **Electronic Patient Record (EPR):** The first phase of the rollout was a great success and EPR Nervecentre is now live in York, Scarborough, Bridlington and our community sites.

- **Bridlington Care Unit:** Mr Barkley stated that, although colleagues had acted with the best of intentions, the correct process had not been followed in relation to the proposed move from inpatient care to community care units and community-based services. He reported that the Trust had listened to the concerns raised. Following consideration of information presented at the emergency Overview and Scrutiny Committee on 11 May, the Board agreed at its most recent meeting to review the planned closure while further work is undertaken in response to the specific questions raised by the Committee.

- **Bridlington Surgical Hub Optimisation Week:** A recent elective surgical optimisation week at Bridlington was a great success and nearly doubled surgical activity, achieved through additional resources and extended use of facilities. The sustainability and learnings from this initiative are being evaluated for future planning.

- **CQC:** In April the CQC carried out an unannounced assessment of the trust's maternity services at York and Scarborough. This was a follow-up to the 2023 inspection, which rated services as inadequate. The inspection team spent two days

in York and two days in Scarborough. The trust received some high-level verbal feedback at the end of the visit. They found no significant areas of concern, although they did flag a small number of issues which were immediately addressed. A big thank you to all those staff involved. The draft report from the CQC is yet to be received.

- **Draft Clinical Strategy:** A draft clinical strategy has been circulated among staff for feedback, with further discussions planned at the July board meeting. The strategy emphasises the development of community-based services and neighbourhood health centres, with discussion of local authority bids for facilities and the need to maximise use of existing trust assets. The Council agreed to hold a joint meeting with the Board on the afternoon of the September Board meeting to discuss the strategy further.

The Council:

- **Received the report and noted its contents.**

Action: Send out invite to joint board meeting (CoG/Board) in September (Mike)

26/21 Chair's Report

Mr Barkley gave an overview of his report which had previously been circulated with the agenda and highlighted the following.

- **Governor changes:** The first is the untimely passing of Prof Nick Bosanquet who was taken ill a few days after the April Board meeting (which he attended as an observer). Jill Quinn and Bernard Chalk have stepped down due to on-going health problems, and Ian Foxley has also stepped down due mainly to family commitments. We welcome a new Stakeholder Governor from the voluntary sector succeeding Jill Quinn, Jim Cannon who has a long significant association with York Older Peoples Assembly.

- **Senior Management changes:** Since the last meeting in March, the trust has welcomed three new members of the Trust Board: Matthew Taylor as a NED succeeding Jenny McAleese, Ian Floyd as an additional Associate NED, and Joe Hague our new Chief Nurse who succeeds Dawn Parkes. A huge thank you to Tara who stepped in and filled just a little gap between Dawn leaving and Jo starting. Polly, the previous director of workforce and OD, has left the trust, with Lydia Larcum acting as interim director and a recruitment process is underway for a permanent replacement.

- **Well-Led Review Findings:** The NHS Providers independent Developmental well-led review was conducted two years after a previous CQC rating of 'inadequate' in the Well-Led domain. The board accepted the findings and recommendations, committing to transparency and implementation of the action plan which has been circulated with the agenda.. Mr. Barkley emphasised the importance of the findings, recommendations made and subsequent action plan given the fundamental role of Governors holding the Board to account through its Chair and NEDs. The progress report as at 30th June will be on the September CoG agenda.

- **Clinical Strategy:** A temporary Director of Strategy, Sarah Coltman-Lovell, has been seconded from the ICB to address capacity issues, with plans to appoint a permanent director in the next financial year. The focus is on strengthening external relationships

and engagement with neighbourhood teams. The Chief Executive, Clare, will lead a trust-wide conversation on organisational values, reviewing and updating the behaviour and accountability frameworks, with engagement activities planned for late June and mid-July.

The Council:

- **Received the report and noted its contents.**

26/22 Performance Report

Mr Barkley and Ms Hansen gave a summary of the report which had previously been circulated with the agenda and highlighted the following:

- **Acute Flow:** The trust has implemented changes to emergency care models, including new assessment units and revised definitions of corridor care. There was discussion about the need for clear communication to staff and the public regarding what constitutes corridor care and 12-hour waits, with a commitment to provide a briefing and improve terminology.
- **Cancer:** There has been year-on-year improvement in cancer treatment waiting times, but delays persist due to shortages of consultant histopathologists and delays in histology reporting. Actions include requesting more detailed reporting to the Quality Committee and improving communication with patients.
- **Diagnostics:** The trust faces challenges in recruiting radiographers and histopathologists, impacting diagnostic capacity, particularly with CT scans and Ultrasound scans. There are ongoing discussions with local universities to address training and recruitment, and the trust is insourcing private companies where possible.
- **Referral to Treatment:** The total waiting list increased significantly as part of data cleansing undertaken in preparation for the transfer to Nervecentre. This process identified and transferred a large number of previously unallocated referrals, resulting in an overnight increase of around 15,000 patients on the waiting list. As a result, the Trust was approximately 16,000–17,000 patients behind its year-end target.
- **Workforce:** The Council discussed workforce issues, including the recruitment of additional midwives to meet national standards, sickness absence rates, and the transition of key staff roles within the trust. The Council were informed that the trust is increasing its funded establishment of midwives, aiming to recruit 13 more each year for the next two years to meet national standards.
- **Financial Performance Metrics:** The Council heard that, without an agreed plan or deficit support funding, the Trust is likely to face cash difficulties by September or October. Work is therefore under way with NHS England to prepare an emergency cash application, which would involve a formal approval process, tighter financial controls and short-term repayable support.
- **National Operational Framework Rank Oversight**: Latest figures show that the trust is ranked 129 out of 134 and sits in segment 4. The trust has improved scores on 10 of the metrics, 9 scores have got worse, and 4 have stayed the same. Despite improvements progress has been slow, hence only moving up 2 places.

The Council asked how the significant reduction in 12+ hour trolley waits had been achieved. Mr Barkley explained that this had resulted from a range of measures, including changes to the emergency department model of care, which have improved senior clinical decision-making, changes to the availability of trolleys and beds within that model, and a strong focus on escalation and discharge processes to improve patient flow. He noted that further work

is still required and confirmed that reducing corridor care remains one of the Chief Executive's key priorities.

The Council expressed concern that the addition of equipment to a trolley appeared to result in the patient no longer being classified as receiving corridor care, despite no apparent change in the care being provided, and questioned whether this represented manipulation of the statistics. Mr Barkley explained that the Trust is applying new national guidance on the organisation of emergency departments. Under this model, patients may be moved to designated clinical areas, such as SDEC or EAU, to receive appropriate treatment. Although they may still remain on a trolley, they are not recorded as 12-hour waits because they are receiving care in a clinical setting rather than waiting for admission to a bed.

Mr Hague added that any patient being cared for in an inappropriate area, in line with the agreed definition, is still recorded as receiving corridor care, and reiterated that the intention is to eliminate this practice. He further explained that changes to emergency care pathways mean some patients may remain on a trolley beyond 12 hours while receiving specialist care in a more appropriate clinical environment, with privacy and dignity maintained. In such cases, they are not classified as either 12-hour trolley waits or corridor care. He confirmed that he would ensure staff are clear on how patient care is classified.

The Council discussed delays in histopathology reporting and the impact this is having on delivery of first treatment within 62 days. It was noted that some specimens are being sent to an external provider, with results in some cases taking up to six weeks to be returned, which in turn delays confirmation of diagnosis and the start of treatment. Members heard that the Trust has only around half of the consultant histopathologist capacity it requires, reflecting both a significant national workforce shortage and wider pressures across diagnostic services. Additional local factors were also noted, including accommodation constraints that may affect recruitment.

The Council questioned the reporting of performance metrics with annual comparisons rather than comparing more up to date trends. A change in metrics was requested including:

- Add the number of patients on corridor care in Acute Flow
- Change the metric name to number of 12+ waits and delete trolley in Acute Flow
- Change the number of cancer patients to a figure instead of a percentage

Mr Barkley informed that more detailed information is available in the Trust's Performance Report that is published with the Public Board papers each month.

The Council:

- **Received the reports and noted the contents.**

26/23 Cancer Update

Ms Hansen gave a summary of the report which had previously been circulated with the agenda and highlighted the following:

- **Diagnosis Rate and Patient Impact:** The cancer diagnosis rate was the highest ever recorded, but only 77% of patients received a definitive diagnosis, leaving 30% uncertain about their condition. The team is working to address this gap, linking efforts to pathology prioritisation and result management.

- **Treatment Timeliness:** The thirty-one day standard for treatment post-diagnosis has remained above 96%, ensuring most patients receive timely care once diagnosed.
- **Referral Growth and Pathway Inefficiencies:** An 11% year-on-year increase in cancer referrals was noted, with Ms Hansen explaining that this growth is influenced by population changes, new pathways, and primary care referral patterns. Pathway inefficiencies and referral quality issues are being addressed in collaboration with GPs to improve information and streamline processes.
- **Improvement Plans and Tumour Site Focus:** Improvement efforts are concentrated on five main tumour sites—dermatology, colorectal, gynaecology, urology, and lung cancer—through pathway redesign and straight-to-test rapid diagnostic pathways, aiming to speed up diagnosis and focus resources on patients most likely to have cancer.
- **Primary Care Collaboration and Referral Guidance:** Mrs Hansen discussed ongoing work with primary care colleagues to develop guidance and improve access to diagnostics, aiming to reduce unnecessary referrals and ensure those with genuine cancer risk are prioritised.

A question was raised about how the Trust's 10-year plan to move towards a more community-based model would align with rising cancer referrals and could it realistically be managed outside the hospital setting. Ms Hansen explained that this is part of the wider pathway redesign work. One of the key frustrations for primary care colleagues is the difficulty of securing timely access for patients once they are referred. As a result, where there is any concern that symptoms may indicate cancer, GPs may feel they have little option but to use the cancer referral pathway.

The discussion highlighted the need for a more effective interface between primary and secondary care, including quicker access to specialist advice and guidance, alongside improved diagnostic support. This would help clinicians rule out cancer earlier where appropriate and reduce the number of patients entering the cancer pathway unnecessarily, allowing services to focus on those who most need urgent treatment.

A question was raised about what lies behind the reported 11% year-on-year increase in cancer referrals. It was explained that referral volumes fluctuate over the course of the year and are influenced by a range of factors, including awareness campaigns, changes in primary care, the introduction of new pathways and improved access to diagnostics. The increase does not necessarily mean that more people have cancer. Similar patterns are being seen nationally, with referral spikes often linked to public awareness activity and earlier investigation of symptoms.

A further question explored whether the current year-on-year increase in referrals could be brought down in future, and whether the recent 11% growth is likely to continue. Ms Hansen replied that referral numbers are unlikely to fall significantly in the short term until neighbourhood-based services and the interface between primary and secondary care are working more effectively. In the meantime, improved access to diagnostics means that more patients are being referred earlier, when treatment may still be possible, rather than later when options may be more limited.

It was noted that national policy is rightly encouraging earlier referral, because one of the reasons cancer outcomes in this country remain poorer than they should be is that too many patients are diagnosed at a late stage. Earlier diagnosis at stages 1 and 2 depends on referring patients even when only small suspicions are present. The overall aim is not simply

to reduce referral numbers, but to ensure that the right patients are referred through the right pathway at the right time.

The Council:

- **Received the report and noted its content.**

26/24 Patient Experience Quarterly Report

Mr Hague reported that there has been positive progress in a number of areas since quarter four. Some actions linked to the delayed EPR rollout and related digital solutions have slipped, but these are now being reprioritised for quarter one. He highlighted the following:

- **Training and Complaints Progress:** There has been good uptake of training in health coaching, person-centred care and complaints handling, although it was acknowledged that further work is still needed. Progress has also been made in reducing the complaints backlog, which has fallen from around 250 cases to approximately 50. Response rates are improving, and care groups are engaged in continuing that progress, although further improvement is still required.

- **Translation Services and Tendering Challenges:** Ongoing legal challenges have delayed updates to translation service tendering, but mitigations are in place and processes continue to support patient needs.

- **Patient Experience Metrics and Communication:** It was noted that patient feedback continues to highlight concerns about communication and delays across care pathways. In response, work has begun to reshape patient experience metrics so that they provide a more meaningful and triangulated view of improvement. The intention is to move beyond monitoring complaint numbers and response rates alone, and instead measure whether actions are leading to tangible improvements in the underlying issues raised by patients.

The Council raised concern relating to non-compliance with parts of the NHS Accessible Information Standard, and sought clarification on which elements the Trust is currently unable to meet. Mr Hague responded that further work is needed to ensure full compliance with the Accessible Information Standard, particularly in relation to identifying required adjustments, staff awareness and training, and the effective use of EPR to flag and share information. A fuller response will be provided once the details have been reviewed.

The Council:

- **Received the report and noted its content.**

26/25 Staff Survey Report

Ms Larcum gave a summary of the report which had previously been circulated with the agenda and led a discussion on staff survey feedback, noting increased participation and improvements in key metrics, but ongoing challenges with culture, bullying, discrimination, and basic resources, with a new corporate action plan focusing on values, safety, decision-making, and essentials, and demographic analysis of inclusion scores. She highlighted the following:

- **Survey Participation and Key Metrics:** Staff survey completion rates improved significantly, with nine key metrics showing progress, though only one met national averages, indicating substantial work remains to enhance staff experience.

- **Corporate and Local Action Plans:** A new approach was adopted, focusing on four high-level areas: values, culture and behaviours, safety, influence in decision-making, and ensuring basic resources, with responsible officers and timescales outlined for each.

- **Culture, Bullying, and Discrimination:** Concerns about culture, bullying, and discrimination were discussed, with Lydia emphasising the need to eliminate these issues and the Chief Executive set to lead major conversations to address them.

- **Inclusion Scores and Demographic Analysis:** Inclusion scores are broken down by demographic, staff group, and area, with ongoing analysis to ensure equitable experiences across all groups.

- **Basic Resources and Equipment:** Only 51.6% of staff felt they had the equipment needed to do their work, prompting prioritisation of resource provision and process improvements through the Advance Change initiative.

It was reported that the Trust's response to colleague feedback has two strands: a corporate action plan and bespoke local improvement plans for each care group and corporate area, based on their specific survey feedback. The corporate action plan takes a more focused approach than in previous years, concentrating on four priority areas intended to deliver the greatest improvement in colleague experience:

- values, culture and behaviours
- patient safety, care and dignity
- ability to influence decision-making and drive improvement
- the basics

The local improvement plans set out the key actions, timescales and responsible officers for each priority area.

In response to a question about whether the survey questions are set nationally and whether the Trust can include its own bespoke questions, Ms Larcum explained that there is flexibility to add local questions. However, this is not usually done because the survey is already very long. There is the opportunity to add verbatim comments which are reviewed as they give a little more depth to the scores.

A question was raised about the reported inclusion scores, which appeared positive when compared with the target. Clarification was sought on whether the data had been broken down by demographic group, to ensure that positive overall scores were not masking poorer experiences among particular groups.

It was confirmed that the survey data is analysed in detail by demographic, staff group and service area. The information presented in the report was described as a high-level summary, with more detailed analysis being undertaken to understand the experience of different groups across the organisation.

A question was raised about the reported inclusion scores, which appeared positive when compared with the target. Clarification was sought on whether the data had been broken down by demographic group, to ensure that positive overall scores were not masking poorer experiences among particular groups. Ms Larcum confirmed that the survey data is analysed in detail by demographic, staff group and service area. The information presented

in the report was described as a high-level summary, with more detailed analysis being undertaken to understand the experience of different groups across the organisation.

A further question was asked about how reports of bullying and harassment in the survey should be interpreted, specifically whether these responses reflected formally investigated cases or individuals' personal perceptions.

It was explained that the survey responses reflect how colleagues feel and how they have chosen to respond to the survey. This means that reported experiences of bullying or harassment may not necessarily have been raised through formal reporting routes, but are nonetheless captured through the annual staff survey.

A question was raised about the staff survey finding that only 51.6% of respondents felt they had adequate materials, supplies and equipment to do their job. It was observed that this suggested around half of the workforce did not feel their basic needs at work were being met, and clarification was sought on where the Trust was starting in addressing this issue. Ms Larcum explained that this issue is reflected in the basics priority within the delivery plan, as it relates to the wider concern that fewer than half of colleagues would currently recommend the organisation as a place to work. This area of work focuses on ensuring that colleagues have the fundamental support they need, including:

- access to appropriate rest areas
- access to adequate equipment and supplies
- clear and straightforward processes for obtaining what they need to do their job effectively

It was reported that some of this work had already begun through the Our Voice Our Future programme and the change-makers initiative. This will continue, with a focus on simplifying processes, removing practical barriers, and helping colleagues understand how to access the support and resources already available. It was noted that feedback from staff discussions and focus groups suggests that, in some cases, support is available but colleagues do not always know how to access it. This work will therefore align with the wider conversations on values and behaviours, and will form part of the broader programme to improve colleague experience.

The Council:

- **Received the report and noted its content.**

26/26 NED Assurance Questions

Mr Barkley explained that the questions had been circulated prior to the meeting and will be answered at the meeting. Responses were given below:

Q1: Are the NEDs assured that there will be sufficient public participation in the formulation of the Trusts Clinical Strategy? Can you explain to the Governors how you came/ how you will come to this assessment.

A1: The Non-Executive Directors were not yet able to give assurance on the extent of public participation in the development of the Trust's Clinical Strategy, as the Board had only considered an early draft informed mainly by internal and partner discussions. It was noted that governors would be involved through the proposed joint meeting in September.

It was further noted that public engagement, beginning in July in Bridlington and later in other localities, would focus on implementation of the strategy in different areas. The planned constituency meeting on the East Coast in September may provide an opportunity either to present emerging findings or to support further engagement, depending on progress.

Q2: Are the NEDS assured that in services where there are long waits for a first appointment (48 weeks for an Ophthalmology Appointment provides an example) there is equity of access to the service across the different hospital sites of the Trust? What data could they provide to demonstrate this assurance to the Governors.

A2: Attached (appendix 1) are the latest non-urgent waiting times by specialty and location.

The Non-Executive Directors clarified that they review performance primarily at Trust level, rather than routinely by individual hospital site. Assurance is therefore based on overall RTT performance and the principle that patients are treated in clinical priority and chronological order. It was acknowledged, however, that the Trust is not assured in relation to meeting the 18-week standard, as waiting times for non-urgent patients remain significantly above this level. While more than half of patients are still seen within 18 weeks, many continue to wait between 18 and 52 weeks.

It was confirmed that there are differences between sites and specialties, with some services showing notably longer waits in Scarborough than in York. The NEDs explained that these differences are influenced by several factors, including:

- variation in available equipment and facilities
- historic commissioning arrangements
- challenges in recruiting and retaining staff, particularly on the east coast

It was noted that the Trust's clinical strategy aims, where possible, to reduce these differences and improve equity of access across sites.

Q3: Are the NEDs assured that we have a grip on the Appearance and Workwear Policy when so many members of staff arrive and leave the hospital in scrubs?

A3: The NEDs do not yet have full assurance that appearance and workwear standards are being applied consistently. The relevant policy is being reviewed to ensure it aligns with infection prevention and control requirements. Further work will also be needed to embed the policy effectively and support a culture in which the expected standards are consistently understood and followed across the workforce.

Q4: As Governors of the Trust, it is of course incumbent on us to always act in the best interest of the Trust, however, the potential removal of the Bridlington Care Unit (BCU) strikes at the heart of the people of Bridlington, Driffield and the environs. The majority of the 'patients' in the unit have been from this locality and many have been readmitted back to Scarborough Hospital following a period in the BCU. So, please can the following questions be asked:-

1. It is understood that funding for the BCU was split between the ICB and YST on a ratio of approximately 70 - 30. Which organisation forced the issue by withdrawing their funding first?

A: The Bridlington Care Unit was fully commissioned by the Integrated Care Board (ICB). The Unit required trust funding because the cost of operating it exceeded the funding received, creating an overspend that the trust had to manage. This funding is no longer available and needs to come from elsewhere.

2. it has been publicly announced that the funding for the BCU has been diverted elsewhere however, there has been no further information provided around the destination of the funds. Please can the destination of the diverted funding be disclosed.

   A: This would need to be answered by the ICB.

3. It has been rumoured that additional beds have been provided since the soft closure of the BCU in Scarborough to provide capacity for those patients who would ordinarily have been moved to the BCU. Please provide an update on the bed situation in Scarborough where potential overcrowding has been implemented into certain wards.

   A: There are no additional beds being created at Scarborough Hospital.

4. How was the decision made to commence the closure of the BCU without proper 'public engagement' (especially within the guidance in B1762 Working in Partnership with People and Communities). Has it been established that the Care in the Community is robust and mature enough to cope with the closure of the BCU?

   A: It is acknowledged that issues arose because the Trust's communications policy and procedure had not been followed by a number of individuals. The Trust acknowledged that its handling of communications in this matter had been unacceptable and not in line with policy, and an apology was given for those failings.

5. Please can the Directors update the Governors on the progress of the recommendations from the Health Overview & Scrutiny Committee (HOSC) meeting at East Riding of Yorkshire Council on 11 May.

   A: The Board has submitted a detailed response to the HOSC, addressing the recommendations made. Work to implement those actions is now being taken forward by relevant colleagues.

Q5: Please can the Trust update Governors on the progress of the Palliative Care Pilot at Bridlington Hospital.

A5: The proposed palliative care pilot did not proceed and has since been discontinued. The pilot involved four beds funded by the ICB for palliative care, and work had been undertaken to assess how this could be mobilised. However, it proved difficult to deliver a clinically and financially viable model of medical cover for only four beds within the funding available. Discussions continue as part of the wider strategy work and that this issue will also form part of the public engagement planned over the summer. This will include consideration of what future palliative care provision may be needed locally and the importance of earlier recognition of palliative care needs. There is no hospice provision in Bridlington and any local palliative care service would need to be formally commissioned in order to be delivered.

With regard to Q2, a concern was raised that some patients believed cancelled appointments may have reset their waiting time. It was confirmed that cancelling an appointment does not reset the RTT clock.

It was noted that the Board receives information and assurance about the actions being taken to improve waiting times, but that this does not equate to assurance that standards are currently being met. The Trust's three-year plan includes actions to increase the proportion of patients seen within 18 weeks, although it was acknowledged that progress is constrained by the financial savings required and the limited ability to invest in additional capacity.

It was further noted that balancing these competing pressures is a fundamental challenge for the Trust Board and that there are no simple short-term solutions.

A question was raised about whether longer waits for elective review can lead to deterioration in patients' conditions and increased emergency admissions. It was confirmed that national evidence suggests this can occur, although no local analysis had been undertaken. It was suggested that this should be considered further as part of work on service planning, workforce and estates.

With regard to public engagement, the Council asked when the engagement sessions will be publicised. Mr Barkley replied that an engagement plan is being finalised and would be shared with the HOSC in response to one of its recommendations. Engagement activity is expected to take place during July, with event dates currently being confirmed. The engagement would not be limited to public events alone, as the Trust intends to present a fuller programme of activity. It is anticipated that the complete plan would be available within the following week and, in addition to the HOSC, will be shared with governors, the Health Forum and other stakeholders.

Action: Share engagement plan with the governors (Martin)

26/27 Reports from Board Committee Chairs

Quality Committee

Mrs Boyd noted that the summary of the previous four meetings provided a broad overview of the range of issues considered by the committee.

Two recurring themes were highlighted:

- **Patient experience** - particularly complaints, complaint responses, and the level of assurance available from this information.

- **Safety of care in the Emergency Department** - including increasing scrutiny of care delivered in ED and in other areas not designed or recognised as ward spaces.

It was noted that these issues had already been discussed earlier in the meeting, and no further specific points were highlighted.

Resources Committee

Mrs Grantham reported that the committee has considered a wide range of issues and continues to oversee a substantial and challenging agenda.

- **Finance and performance:** The Committee has focused in particular on the Trust's financial position, noting that performance in the first month was behind plan and savings delivery was below target. It was emphasised that, while the external financial context remains challenging, the Committee's role is to hold the Executive to account for delivery and to scrutinise the actions required to bring performance back on track.

- **People, culture and leadership:** The Committee has also considered workforce matters, including the colleague survey. It was noted that, while there are early signs of improvement and the previous downward trajectory has been halted, the Trust remains some way from where it needs to be in relation to colleague experience. Culture and leadership were highlighted as critical issues, both in terms of staff experience and the delivery of safe, high-quality patient care.

- **Operational performance:** The Committee has received regular updates on performance improvement. It was noted that there has been some improvement in urgent and emergency care, while significant challenges remain in diagnostics. Cancer performance was described as showing some positive results, although not yet at the required level.

Group Audit Committee

Mrs Hazelgrave reported that, in addition to the meeting summary provided, the Committee had also met in May.

- **Final accounts and external audit:** The Trust is now approaching completion of the final accounts, with an extraordinary Board meeting scheduled for the following week to review them. It was noted that no issues had been raised by the external auditors and that sign-off of the accounts was expected. A further detailed review of the accounts was due to take place with the finance team.

- **Internal audit:** It was noted that a number of internal audit reviews had received limited assurance opinions. However, these related to areas deliberately included in the audit plan because known risks or weaknesses had already been identified, with the intention of supporting improvement in systems and processes.

The Council was advised that the year-end overarching internal audit opinion was expected to be significant assurance, which was considered a positive position.

It was further reported that the number of outstanding audit recommendations had reduced significantly compared with the previous year, although further work remains to ensure that overdue actions are completed on time.

To strengthen governance, a revised process is being introduced whereby the Audit Committee will approve any requests to extend action deadlines. This is intended to ensure that actions are progressed in a timely way and not repeatedly deferred.

It was noted that the annual counter-fraud assessment remained rated green, indicating compliance with the relevant standards.

The Council:

- **Received the report and noted its contents.**

26/28 Governance Update

Mr Taylor gave a summary of the report which had previously been circulated with the agenda and highlighted the following:

Constituency Changes

The proposed constitutional changes, which are minor and non-controversial, were discussed at a recent Constitution Review Group chaired by public governor, Sandra Fox. Due to quorum issues at the meeting the Council is asked to ratify the changes proposed.

The Council:

- **Ratified the proposed constitutional changes.**
- **Received the report and noted its contents.**

26/29 Items to Note

The Council noted the following items:

- CoG Attendance Register
- NED Attendance Register

26/30 Any Other Business

No further business was discussed.

26/31 Time and Date of the next meeting

The next meeting is on Wednesday 9 September 2026 at Malton Rugby Club

Appendix 1

Indicative Max Wait Times -

	Upper Routine Wait Time (Weeks)				
TFC	Bridlington	Malton	Scarborough	Selby	York
Audiology	15	18	16	16	13
Cardiology	52	52	46		52
Colorectal	42	37	30		44
Dermatology		42		52	52
Diabetes	25	29	38	14	18
Endocrinology	36	37	36	50	52
Ear, Nose and Throat	52	49		50	50
Gastroenterology			29		47
General Surgery	46	52	49	34	37
Gynaecology	52	52	52	42	43
Hepatology			48	40	38
Neurology					44
Ophthalmology	38	44	45		32
Oral Surgery	52		52		42
Paediatrics	38	37	41	40	40
Pain Management	52				
Respiratory	34	40	37		52
Rheumatology	26	14	25		20
Upper GI	52	30	51	36	41
Urology		51			
Vascular	51		52	52	47

Indicative maximum wait for general services for these specialties. Exclude specialist services.
Specialties listed on RAS.